FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: ABE DATE: 4/6/04
INMATE'S NAME: Donald Morrison DETAIL: Chapel REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) Ttotally DISABLED:
( ) FULL DUTY: medically unassigned

H. BEAM, MD
FCI MCKEAN

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000300

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 1/6/04
INMATE'S NAME: Donald Mosher DETAIL: Unassigned REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
(X) TOTALLY DISABLED: 3 mo
( ) FULL DUTY:

H. BERTRAM MD
FCI McKEAN
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000207

FEDE CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED
INMATE'S NAME: Mosher, Donald
UNIT: AB
DETAIL: unassigned
DATE: 12/3/13
REG. NO.: 10904-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ **THRU 12 MIDNIGHT** _____, 19 ___

(✓) CONVALESCENCE: List any restricted activity for medical reasons. _____ **THRU 12 MIDNIGHT** 12/10/2003, 19 ___

( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ **THRU 12 MIDNIGHT** _____, 19 ___

( ) TOTALLY DISABLED:

( ) FULL DUTY:

A Labrego
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - Temporary disability not to exceed three days duration including weekends and holidays. Restricted to quarters except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Full institutional recreational privileges, subject only to medical limitation.
RESTRICTED DUTY - Restricted from work around machinery, heights, heavy lifting, etc., because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical resons. Condition generally expected to last indefinetely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

2- Housing Unit ( ) 3- Detail Supervisor 4- Sentry/Medical Records 5- Inmate Copy

000309

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 11/30/03
INMATE'S NAME: Moshier, D DETAIL: unassigned REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(✓) IDLE: Reason Medical THRU 12 MIDNIGHT 12/3/03 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000303

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED
INMATE'S NAME: Donald Moslin UNIT: AB DATE: 10/31/03
DETAIL: Orderly REG. NO.: 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ **THRU 12 MIDNIGHT** _____, 19 ___

( ) CONVALESCENCE: List any restricted activity for medical reasons. _____

_____ **THRU 12 MIDNIGHT** _____, 19 ___

( ) RESTRICTED DUTY: Specify exact restriction and reason. _____

_____ **THRU 12 MIDNIGHT** _____, 19 ___

(X) TOTALLY DISABLED: medically unassigned x 3 months

( ) FULL DUTY:

H. BEAM, MD
FCI MCKEAN
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - Temporary disability not to exceed three days duration including weekends and holidays. Restricted to quarters except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Full institutional recreational privileges, subject only to medical limitation.
RESTRICTED DUTY - Restricted from work around machinery, heights, heavy lifting, etc., because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical resons. Condition generally expected to last indefinetely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

3- Detail Supervisor 4- Sentry/Medical Records 5- Inmate Copy

000304

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FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 10/31/03
INMATE'S NAME: Mosher, Donald DETAIL: CMS REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason medical THRU 12 MIDNIGHT 10/31 19 2003
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000305

FEDERAL CORRECTIONAL INSTITUTION, HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 9/30/03
INMATE'S NAME: Meshier, Donald DETAIL: orderly REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) ~~IDLE~~: Reason Medical THRU 12 MIDNIGHT 10/2 ~~19~~ 03
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

J Glenn FNP-C

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000306

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 9/18/03
INMATE'S NAME: Mosher, Donald DETAIL: Orderly REG. NO. 10929-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Medical THRU 12 MIDNIGHT 9/19/03
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Bonnie Saylor
Physician or Physician Assistant

BONNIE SAYLOR, NP
FCI MCKEAN

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000307

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 6-13-03
INMATE'S NAME: Moshier, Donald DETAIL: Kitchen REG. NO. 10934-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(✓) IDLE: Reason medical THRU 12 MIDNIGHT 6/16/03 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Steven Labrozzi, PA-C
Physician Assistant
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000308

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 9/15/02
INMATE'S NAME: Mosher, Donald DETAIL: Elec II REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(✓) IDLE: Reason Medical THRU 12 MIDNIGHT 9/17 19 02
( ) CONVALESCENCE: List any restricted activity for medical reasons. THRU 12 MIDNIGHT ____ 19 ____
( ) RESTRICTED DUTY: Specify exact restriction and reason. THRU 12 MIDNIGHT ____ 19 ____
( ) TOTALLY DISABLED:
( ) FULL DUTY:

J Glenn

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000309

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 9/12/02
INMATE'S NAME: Mashica, Donald DETAIL: Elec 2 REG. NO. 10924-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(✓) IDLE: Reason Medical THRU 12 MIDNIGHT 9/13 2002
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

J Glenn

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000310

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AB DATE: 9/10/02
INMATE'S NAME: Mosher, Donald DETAIL: _____ REG. NO. 10424-052

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) for the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(✓) IDLE: Reason Medical THRU 12 MIDNIGHT 9/11/02
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Maria Feinbaum PA
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious s call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Exc and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific da
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

000314

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution FCI McKean	2. Name of Injured Moshier, Donald	3. Register Number 10924-052
4. Injured's Duty Assignment CMS	5. Housing Assignment AB	6. Date and Time of Injury 10/30/03 630 PM
7. Where Did Injury Happen (*Be specific as to location*) Shakedown shack	*Work Related?* ☐ Yes ☒ No	8. Date and Time Reported for Treatment 10/31/03 0640

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

Slipped on the mud and hurt my back and neck. I have sharp pain shooting down my left leg really bad pain 7/10

X

Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken ____ *Not Indicated* X
X-Ray Results

NAD

Back: palpable spasm of Ⓛ lower back, tender to palpation
⊖ deformity ~ mech – wnl

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

① LBP 2° spasm

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

① Education – stretches – Pt understands ④ f/u PRN
② idle + 24 hours quar
③ Ibuprofen 800 mg i PO TID dispense #9 R-O

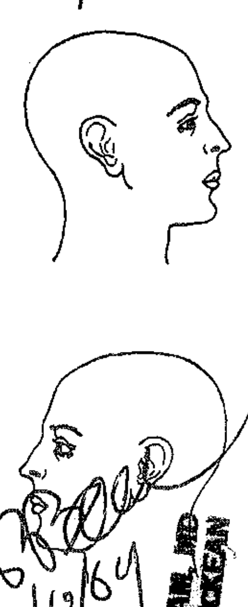
13. This Injury Required:

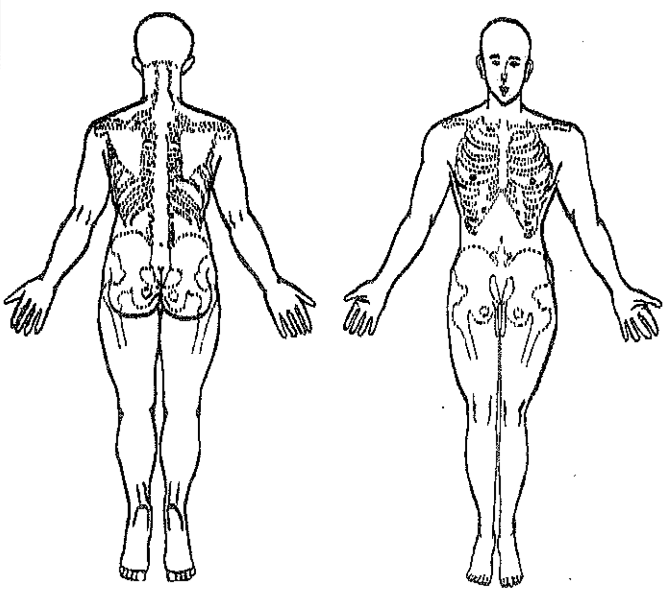
☐ a. No Medical Attention
☒ b. Minor First Aid
☐ c. Hospitalization
☐ d. Other (*explain*)

☐ e. Medically Unassigned
☐ f. Civilian First Aid Only
☐ g. Civilian Referred to Community Physician

Eric Asp PA-C
Signature of Physician or Physician Assistant

Eric Asp, PA-C
REVIEWED BY
H. Beam 11/6/04
H. BEAM, MD
FCI MCKEAN





If Carboned Form – If ballpoint pen is used, **PRESS HARD**

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)

000312

U.S. Department of Justice
Federal Bureau of Prisons

Medical Treatment Refusal
(Rechazo de Tratamiento Médico)

Date 5/23/02 (Fecha)

I, Moshier Jr Donald 10924-052, refuse treatment recommended by the Federal
(Name and Registration Number) (Nombre y Número de Registro) (rechaza el tratamiento recomendado por el Personal

Bureau of Prisons Medical staff for the following condition(s):
Médico del Bureau Federal de Prisiones, por las siguientes razones):
DESCRIBE IN LAYMAN'S TERMINOLOGY: (DESCRIBA EN TERMINOLOGIA COMUN Y CORRIENTE):

Rectal Exam

The following treatment(s) was/were recommended: (El siguiente tratamiento(s) fue/fueron recomendado(s)):

- Prostate.

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento):

- To rule out Ca or any pathological Condi'n

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions.

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehuso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por cause de respectar y seguir mis expresos deseos y direcciones.)

Donald C Moshier Jr
Patient's Signature and Date (Firma del Paciente y Fecha)

ARUN VERMA
Signature of Witness and Date (Firma del Testigo y Fecha)

Signature of Witness and Date (Firma del Testigo y Fecha)

000313

Original – Inmate's Medical Record

BP-S621.060 SEP 03 AUTHORIZATIO. FOR RELEASE OF MEDICAL INFO. MATION CDFRM 3/916

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

Inmate Name	Register Number	Date
Moshier, Donald	10924-052	10-18-05
	Date of Birth: 8-18-61	Social Security Number: 096528139

I hereby authorize and request the Federal Bureau of Prisons to:

☐ release information to, or ☒ obtain information from

Name/Facility: Kane Community Hospital

Address: N. Fraley Street / Box 778

City, State, Zip: Kane PA 16735

PLEASE CONTACT IF PAYMENT IS REQUIRED PRIOR TO FILLING REQUEST

I understand the information is to be used for (specific reason for release of information):

☒ Continuation of care, or ☐ Other _____

Information to be Released/Obtained: Copy of and/or information from my medical file pertaining to my evaluation and treatment received from 6-2002 to 4-2005

This is to include: ☒ Complete Record ☐ Discharge Summary ☐ History & Physical

☐ Operative Reports ☐ Consultations ☐ Progress Notes ☐ X-ray Reports

☐ Laboratory Reports ☐ Pathology Reports ☐ Actual Films*# ☐ Actual Slides*

☐ Other: _____

*will be returned
#duplicates accepted

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically expire three months from the date of the signature.

Signature of Patient	Date (Month, Day, Year)	Staff Witness
Donald C Moshier JR FAX SIGNATURE VALID ORIGINAL 10924-052	10-18-05	Kim Ely, Ht

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.
Must sign below, to Release Protected Information.

I specifically authorize the release of data and information relating to:
☐ 1. Substance Abuse ☐ 2. Mental Health ☐ 3. HIV

_____ Signature _____ Date

Deliver Records To: (Institution Address & Fax number)

USP LEWISBURG
HEALTH SERVICES UNIT Po Box 1000
LEWISBURG, PA 17837

fax: 570-522-7764

000314

Packet received 12.23.2005 [illegible]

(This form may be replicated via WP)

This form replaces BP-S621 Dtd AUG 96

EMERGENCY ROOM RECORD — KANE COMMUNITY HOSPITAL — KANE, PA 16735

Medical Record #

Last Name: Moshier First Name: Donald Middle Name: L
Home Phone / Admission Date / Time / A.M./P.M.
Address / City / State / Zip
Status
Employer / Address
Next of Kin / Address
Guarantor / Guarantor Address
Physician / Family Physician: Dr. Anderson / Arrival Mode of
INSURANCE

MOSHIER, DONALD
PO BOX 5000
BRADFORD PA 16701
08/18/1961 31916/
FREEMAN, RICHARD E 04/14/05 286109
111111111 M 43 E R

Sex / Civil / Religion / Phone
Last O/P Visit Date / Last I/P Dis. Date / Last I/P Adm. Date / Initials

Substernal C.P. Onset Date: Tues. Onset Time

PFSH: Past Medical, Family, and Social History: 0 history areas=L1, L2, or L3 1 history area=L4 2 history areas=L5

Present Meds: ☐ See attached
lactulose 15cc Bid
albuterol II puff qid
[illegible]
tylenol
Vantecs
Pegylated Interferon 180 mcg SC weekly
Ribavirin po 600mg Bid

TETANUS HX:
Date of last Tetanus:
☐ Td Information given
Manufacturer
Lot#
Expiration Date
W/

ALLERGIES:
Rice (swelling)
UKDA
LATEX: Y (N)

Family History:
Diabetes Y N
HTN Y N
Heart Disease Y N
COPD Y N
Cancer Y N
Other: Non contributory

Social History:
Tobacco Y (N)
amt./freq.:
ETOH Y (N)
amt./freq.:
Occupation: FCI inmate
Other:

Past Medical:
☒ ASTHMA
☐ CAD/MI
☐ CHF
☐ COPD
☐ DM
☐ CVA
☐ HTN
☐ NONE OF ABOVE
☐ OTHER: Hepatitis C, cirrhosis, Low back pain, GERD

Surgical:
☒ Appendectomy
☐ Bowel Surg.
☐ Cardiac Surg.
☐ Cholecystectomy
☐ Hernia repair
☐ Hysterectomy
☐ Laminectomy
☒ Ortho. Surg.
☐ Tubal Ligation
☐ NONE OF ABOVE
☐ OTHER

LNMP: N/A
Weight:
Visual Acuity:
Without Correction: N/A
OD ____ OS ____
With Correction:
OD ____ OS ____

PEDIATRIC PARAMETERS
Height
Weight
Head Circum. NA
☐ Childhood immun. UTD

FIRST AID: None

History obtained from: (Patient) EMS Family Caregiver Other FCI inmate
Unable to obtain history due to:

TRIAGE TIME: 1204 **TIME PHYSICIAN NOTF'D:** 1206 **ESI:** 1 2 (3) 4 5

Nursing Assessment: 1204 C/O C/O substernal chest pain → epigastric area radiating to back, ambulatory brought in by FCI guards x2. Hands & feet shackled. A&Ox3. Cooperative. Color pink. Skin warm & dry. Resp s distress. No peripheral edema. — BA RN
1240 Gastrografin started 800cc. taken in 10 minutes
1315 C/O chest pain - 11/10 pain scale. - Dr. Freeman notified. Med c toradol 30 mg IVP — BA RN
1305 Report received from Dr. Bream & hepatic —
1345 Sl relief c toradol — BA
1410 To X-ray via gurney. 1450 Back from x-ray —
1520 To X-ray for [illegible] 15 [illegible] cont. remain shackled — BA

TIME	T	P	R	BP	SPO2
1210	98.2	84	20	170/100	99% RA
1345		80		142/84	

Consultant: Time Notified:

Attending Physician: Time Notified:

☐ Discharged Time:
☒ Admitted RM# 124 Time:
Report Called to: Nancy Kristen, LPN
☐ Transferred To:
Time:

CONDITION:
☐ UNCHANGED ☐ SATISFACTORY
☐ IMPROVED ☐ EXPIRED (PCP Notfd.)

PERSONAL BELONGINGS
☐ SENT WITH PATIENT
☐ GIVEN TO FAMILY

PCP Notified ☐ Verbal ☐ Voice Mail ☐ Other
@

RN SIGNATURE: Barbara J. Anderson RN

000315

EMERGENCY ROOM RECORD
KANE COMMUNITY HOSPITAL
KANE, PA 16735

Patient Name: MOSHIER, DONALD
Patient #/Admission #: 31916 / 286109
Admit Date/Time: 04/14/05 / 12.07
Mode of Arrival: VAN

Age: 43
Date of Birth: 08/18/1961
Sex: M
Home Phone: 8143628900

EXAM 1 = Level 1, 2-7 = Level 2 or 3, 2-7(4x4) = Level 4, 8+systems=Level 5 Note: Levels 1-4=body area or organ systems Level 5=organ systems (underlined)
(SYSTEM/AREA ASSESSMENT: Nml=all items are as listed except those as noted in "abnormal findings". Slash=not assessed)

CONSTITUTIONAL: TEMP PULSE RESP BP SaO2 % on ________ **Comments:**

GENERAL APPEARANCE:

SYSTEM/AREA ASSESSMENT	Nml	Abnormal Findings
Head, incl. face: nml appearance, no scars, symmetrical, no lesions, no masses	/	
Eyes: PERRL, nml. pupil size, nml. conjunctiva, no eyelid edema, EOMI	/	
Ears, nose, mouth, throat: TMs clear, no ENT bleeding, no gum/palate/oral cyanosis	/	
Neck: supple, no tenderness, no masses, no JVD, no bruits, no thyromegally	/	
Cardiovascular: S1, S2 WNL, RRR, no murmurs, no thrills	/	
Respiratory: BS clear & equal, nml. effort, nml. percussion, nml. palpation	/	
GI/Abdomen: Soft, no masses, nml. bowel sounds, no tenderness, no pulsatile mass		No Rebound or guarding BS Active
MSK/Extrem.: No clubbing, no cyanosis, no edema, PPP, FPP/=, nml ROM	/	No masses - No HHS
Genitourinary: Ext. genitalia nml, no DC, no tenderness or fullness of bladder		
Chest, include breasts/axillae: no masses, no tenderness, no discharge	Exquisite	Tender Xyphoid process + CC margin bilat (R) > (L)
Skin: Warm, dry. Turgor good. No cyanosis, jaundice, rashes, ulcers	Acne /	
Neurological: No motor or sensory deficit, DTR WNL, Cranial n. intact	/	Rectal - No masses Hemo Neg
Psychiatric: Alert, oriented x 3, nml affect, normal mood.	/	
Heme/Lymph/Immuno.: No lymph-adenopathy, no hepatosplenomegaly	/	
Back, including spine: no scoliosis, kyphosis, lordosis; no lesions, masses, or scars		
Genitalia, groin, buttocks: no masses, rashes, lesions, erythema; no tenderness, deformity.	/	

ORDERS & RESULTS check to order

	LABORATORY	Init	Result
/	AMYLASE	41	12.9
/	CBC	WBC 2.4	37.4
/	CHEM 7		137 / 105 / 16 ; 3.9 / 26 / 0.9
/	CPK		
	DIGOXIN LEVEL		
	HCG		
	LIPASE		T Bili 1.4
/	LIVER PROFILE	BA	ALT 89 · AST 6_
/	PT	BA	
/	PTT	BA	
	TROPONIN		
/	UA (CX if positive)	BA	Bact 4+
	ABG		
/	EKG		WJR
✓	Pulse OX	BA	
	Blood CX		
	Throat CX		

	RADIOLOGY	Init	Result
☐	X Ray Visualized by examiner		
/	CXR	BA	
	C-SPINE		
	CT HEAD w/o		
	KUB		
/	CT-Abd/pelvis		Acute Cholecystitis
✓	U/S abd. AHU	BA	

PROCEDURES/NARRATIVE/OTHER

☐ Old Records. Review: Anderson - Admit

☐ Case discussed with: Nature of Discussion:

Xyphoid process - Trigger point injection DepoMedrol 40mg & Marcaine 0.5 / cc 25 g. needle - Betadine Local infiltration - good relief of pain

DIAGNOSES:
1. Acute Cholecystitis
2. UTI
3. Xyphoid tenderness
4. Hep C - Hepatic insufficiency
5. Neutropenia

ED PHYSICIAN SIGNATURE: [signature] MD

Critical Care Time: ________ min.*
*This time must not include time spent on seperately billable procedures

☐ PFSH reviewed and confirmed by physician.
☐ See addendum / progress note / dictation

INTRAVENOUS

Time	Site/Guage	Init	Fluid
1250	(L) AC c̄ 20		Heplock/ultiguard BA

IV d/c @

MEDICATIONS AND TREATMENTS

Toradol 30mg IV 1315 BA

000316

EMERGENCY ROOM RECORD
KANE COMMUNITY HOSPITAL
KANE, PA 16735

Patient Name: MOSHIER, DONALD
Patient #/Admission #: 31916 / 286109
Admit Date/Time: 04/14/05 / 12.07
Mode of Arrival: VAN

Age: 43
Date of Birth: 08/18/1961
Sex: M
Home Phone: 8143628900

Time seen by physician:

HPI: History of Present Illness: 1-3 elements = Level 1, 2, or 3 4 elements = Level 4 or 5

Context (story): Modifying factors: Associated signs and symptoms: Severity Quality Location Duration Timing

43 y/o wm - c/o - epigastric pain - x3-4 days constant - radiates to back - worse ē cough + deep breathing nausea - no vomiting or diarrhea - claims to have blood in stool 3 days ago - "when had severe pain." - No fever, chills, cough, SOB diaphoresis - claims he has a "lump" in (2) UQ that is also sore. Recent labs - 4/15 - WBC 1,800 Hct 38% Platelet count 77,000
Hx of Hepatitis C ē Hepatic failure - Interferon/Ribavirin
Chronic Bronchitis/Asthma/GERD
Meds - Interferon, Ribavirin, APAP, Lactulose, Albuterol, Zantac.

REVIEW OF SYSTEMS (elaborate positive findings) 0=Level 1 1=Level 2 or 3 2-9=Level 4 10 or "all other systems negative"=Level5

Constitutional	N	Y	Comments
Fever, sweats	✓		
Sleep problems			
Fatigue			
Weight gain or weight loss	✓		
Skin			
Rashes		✓	Acne - ba[illegible]
Ulcers	✓		
Eyes			
Dry eyes or irritation			
Vision loss or disturbance			
Ears/nose/mouth/throat			
Ear pain	✓		
Hearing loss	✓		
Nose, sinus problems, snoring	✓		
Dry mouth, ulcers, sore throat	✓		
Respiratory			
SOB/DOE	✓		
Cough	✓		
Cardiovascular			
Chest pain or palpitations		✓	
Edema	✓		
Claudication	✓		
Gastrointestinal			
Indigestion or "heartburn"	✓		
Nausea or vomiting	✓		
Constipation or diarrhea	✓		
Difficulty swallowing	✓		
Abdominal pain		✓	

Genitourinary	N	Y	Comments
Frequent urination	✓		
Painful, difficult urination	✓		
DC/bleeding	✓		
Incontinence			
Musculoskeletal			
Muscle aches, arthritis	✓		
Falls			
Gait disorders			
Neurological			
Headaches	✓		
Focal weakness, numbness			
Dizziness, faintness, numbness			
Psychiatric			
Anxiety, depressed mood	✓		
Memory loss	✓		
Behavioral changes	✓		
Endocrine			
Heat or cold intolerance			
Excessive thirst			
Hematologic/Lymphatic			
Easy bleeding or bruising			
Known lymphadenopathy			
Allergic/Immunologic			
Allergic symptoms			

☐ All other systems negative

Additional Comments:

☐ Established problem (to examiner): Stable, improved

☐ Established problem (to examiner): Worsening

KANE COMMUNITY HOSPITAL
KANE, PA

DISCHARGE SUMMARY

NAME: DONALD MOSHIER
ADMITTED: 04/14/2005 DISCHARGED: 04/16/2005
MED REC #: 31916 ADM #: 286109

ADMISSION DIAGNOSIS: Acute cholecystitis

DISCHARGE DIAGNOSIS: Non-cardiogenic chest pain
Probable chronic cholecystitis without cholelithiasis
History of cirrhosis and hepatitis C
Costochondritis

HISTORY: The patient is a 43-year-old male admitted with the history described in his history and physical. He was seen initially from the emergency room where he was complaining of nausea and two weeks of abdominal pain. He described this as mid-epigastric, mid-chest pain actually radiating into his back. He was admitted because of an abnormal ultrasound which was indicative in the radiologist's opinion of acute cholecystitis because of gallbladder wall thickening. There was no enlargement of the common duct. There was no stone seen and his presentation was mildly atypical in this regard. Be that as it may, he was admitted with further work-up for his chest pain, a differential diagnosis entertained. CAT scan of the chest showed no evidence of PE, cardiac isoenzymes were negative. Chest x-ray was unremarkable. EKGs were unremarkable. An upper endoscopy showed no evidence of ulcerations and there were no varices. His pain seemed mostly reproducible, mid-epigastric, more mid-sternal with reproduction and seemed more consistent with costochondritis. His SED rate was slightly elevated. A D Dimer was pending at this time. Generally pulmonary embolism, coronary disease, peptic ulcer disease, aneurismal changes were excluded during his work-up. It was probable that the patient's pain was related to costochondritis. He was advised as per progress note date of discharge, any worsening changing symptoms need further evaluation. A further work-up is necessary perhaps in terms of his gallbladder but definitely in terms of a stress test and echocardiogram to assess any possibility of coronary disease; this can be done as an outpatient in my opinion. In the meantime the patient will continue on Ibuprofen, Tylenol, Interferon, Ribavirin and Amoxicillin 500 mg. t.i.d. Any worsening symptoms, he should be re-evaluated pending these other diagnostic studies. This was described for him in detail and he understood this at the time of discharge.

GARY ANDERSON, D.O.

D: 04/16/2005 0940
T: 04/16/2005 1228
GLA/kb

KANE COMMUNITY HOSPITAL
KANE, PA

HISTORY AND PHYSICAL

Name: DONALD MOSHIER
Admission Date: 04/14/2005
Admission #: 286109
MR#: 31916

CHIEF COMPLAINT: Two weeks of mid epigastric pain.

HPI: The patient is a 43-year-old male with a history of cirrhosis, chronic hepatitis C and was referred from FCI McKean because of chest pain, substernal pain, epigastric area pain. He states he has been having this on and off for the last couple of weeks. It has been worse, especially the last couple days, almost steady. He describes it mostly in his mid chest, into his mid back with some nausea, but no vomiting. He can't eat, although he states his appetite is generally good. He was seen in the emergency room, subsequent CT scan, ultrasound indicative of acute on chronic cholecystitis. He was given Toradol in the ER and his xiphoid area injected, that seemed to help somewhat. He has had no other change in bowel or bladder habits. Denies any hematochezia, hematemesis. He has a notable history for chronic hepatitis C and diagnosed with cirrhosis by a liver biopsy done in Bradford.

PMH: Significant for lumbar disc disease. He has had an appendectomy done years ago. He has had patellar fracture in his left knee in the past.

MEDICATIONS: Ribavirin, Interferon which caused some pancytopenia according to Dr. Bean. He has been on that since October.

SH: Former smoker, quit in December. Heavy drinker but has also quit and has had Hepatitis C secondary to IV cocaine years ago.

ALLERGIES: Rice.

FH: Mother is alive with diabetes. Father is terminal with cancer and diabetes.

REVIEW OF SYSTEMS:
GENERAL: No fever or chills, weight change, or appetite disturbance. EYES: No visual changes, blurred vision, or double vision. ENT: No hearing loss or tinnitus. No nosebleeds or sinus congestion. No hoarseness or difficulty swallowing. CARDIAC: No chest pain, palpitations, or lightheadedness. LUNGS: No productive coughing, wheezing, or hemoptysis. GI: As above. GU: No dysuria, frequency, or urgency. MSK: No clubbing, cyanosis, or edema. No arthralgia. HEMATOLOGIC-LYMPHATIC: No swollen glands, abnormal bruising, or bleeding. ENDOCRINE: No polyuria, polydipsia, heat or cold intolerance. NEUROLOGICAL: No headaches, paresthesia, weakness, numbness, or tremors.

000319

KANE COMMUNITY HOSPITAL
KANE, PA

HISTORY AND PHYSICAL

DONALD MOSHIER (continuation)

ALLERGIES: No sneezing, itchy eyes, or rashes.

PHYSICAL EXAM:
GENERAL APPEARANCE: He appears well, in no distress.

VITALS: T--98, P--84, R--20, BP--142/84.

EYES: Nonicteric. Pupils equal and reactive to light and symmetrical.

EARS, NOSE, THROAT, NECK: Head is normocephalic. Neck is supple without palpable masses. No thyromegaly. Hearing intact to voice. External ears normal. Nares patent. Pharyngeal area clear. No bruits auscultated. Carotid upstroke normal.

HEART: Regular. PMI is in normal position. No lift or heave noted. No S3 gallop.

LUNGS: Clear to auscultation. No rales, rhonchi, or wheezes.

CHEST: Normal excursion and AP diameter. No accessory muscle usage.

GASTROINTESTINAL: Tender in the mid epigastric area. No rebound or guarding. Good bowel sounds in all quadrants. No pulsatile lesions.

HEMATOLOGIC-LYMPHATIC: No adenopathy in the neck or groin.

MUSCULOSKELETAL: No cyanosis, clubbing, or edema.

SPINE: No tenderness or spasm.

PULSE: Radial pulses symmetrical. Femoral pulses palpable and symmetrical.

NEUROLOGIC: No focality. Reflexes symmetrical. Sensory motor exam intact.

SKIN: No rashes or suspicious nevi. Good turgor.

LABORATORY DATA: Ultrasound of the gallbladder shows a distended gallbladder filled with sludge, very thick edematous wall, apparently no stones were seen but consistent with acute cholecystitis according to the radiologist. Urinalysis showed no evidence of bilirubin, positive nitrite, 4+ bacteria. Amylase 44, bilirubin elevated at 1.4, transaminase is 89.65, alkaline phosphatase was 64, BUN 16, creatinine 0.9, sodium 137, potassium 3.9, troponin 0.1, CPK 37, white count 2.4, hemoglobin 2.9, platelets 94, 67% segs and approximately 12 to 1400 neutrophils. EKG shows sinus mechanism.

000320

KANE COMMUNITY HOSPITAL
KANE, PA

HISTORY AND PHYSICAL

DONALD MOSHIER (continuation)

IMPRESSION: A 43-year-old male presenting with a history of cirrhosis, mid epigastric pain, abnormal gallbladder on ultrasound. Differential diagnosis to include cholecystitis acute on chronic, peptic ulcer disease, musculoskeletal pain, doubt myocardial or cardiopulmonary etiologies. Rectal done in the ER heme negative.

PLAN: The patient is admitted to the hospital, started on Toradol for pain, continued on Interferon, Ribavirin, Unasyn intravenously, Albuterol mini nebs. He will be kept NPO after midnight for upper endoscopy tomorrow morning. Risks and benefits were discussed, including the risk of puncturing his stomach, side effects from sedating medication or bleeding. Surgical consultation may be required.

GARY ANDERSON, D.O.

D: 04/14/2005 1706
T: 04/15/2005 0729
GLA:sln

MOSHIER, DONALD 124-2
PO BOX 5000
BRADFORD PA 16701
08/18/1961 31916/
ANDERSON, GARY 04/14/05 286109
111111111 M 43 INPATIENT

PHYSICIAN'S ORDERS

Stopping of an order should be written as a specific order
Automatic Stop Order: Medication orders will follow the policy and procedure on administration of medications. I hereby authorize Kane Community Hospital Pharmacy to dispense a generic equivalent (under the formulary system) unless otherwise indicated.

Height: Weight:
Drug Allergies

Date & Time	Diagnosis: (Acute cholecystitis; UTI; Xyphoid Tenderness Hx Hepatitis C - Hepatic failure	Nurse's Initials
4/14/05 4:49 PM	① Admit Dr Anderson -	
	② IV D.5 NS @ 125 cc/hr - ✓	
	③ NPO	
	④ Activities - as tolerated ✓	
	⑤ Vitals q 4° -	
	⑥ Labs: CBC, Basic/Lipase profile - UA - PT, PTT, Amylase Urine C+S ✓ done	
	⑦ Blood & Fluid Precautions - Hep C	
	⑧ CXR - PA/Lat - ✓	
	⑨ EKG - done ✓	
	⑩ CT Scan Abdomen/Pelvis - done ✓	
	⑪ GB Sonogram - done ✓	
	⑫ Meds: a) Toradol 30mg IV q 6° prn pain ✓ b) Unasyn 1.5gm IV q 6° ✓ c) Ciprofloxacin 500mg po bid ✓ d) Unasyn - 3gm IV q 6° ✓	
	⑬ Albuterol MDI - 2 puff q 4° prn wheezing ✓	
	⑭ Lactulose 30cc po bid ✓	
	⑮ Notify on duty problems contact Dr Anderson.	
	Thank you! Dr Freeman	
4/14/05	NPO p midnight, Comfort diet tonight ✓ Call OR to add for EGD in AM at 8am ✓ Amylase, Lipase & ER labs ✓	

Noted 4/14/05 2045 Mary J. Rudolph

PLEASE! USE BALL POINT PEN ONLY PHYSICIAN'S ORDERS 000322

Chart Forms/Physicians Orders/Dec 04

MOSHIER, DONALD 124-2
PO BOX 8000
BRADFORD PA 16701
08/18/1961 31916/
ANDERSON, GARY 04/14/05 286109
111111111 M 43 INPATIENT

PHYSICIAN'S ORDERS

Stopping of an order should be written as a specific order Automatic Stop Order: Medication orders will follow the policy and procedure on administration of medications. I hereby authorize Kane Community Hospital Pharmacy to dispense a generic equivalent (under the formulary system) unless otherwise indicated.

Height: Weight:
Drug Allergies

Date & Time		Nurse's Initials
	Diagnosis:	
4/15/05	EKG Troponin I D-Dimer, CPK / VS Q15' x4	noted 4/15 845
	Sed Rate this AM / NPO until alert	
	CT Scan chest today	
	Echocardiogram today	
	[signature] DO	
4/16/05	Discharge	
	[signature]	
	Noted [signature] 4/16/05 0950	

PLEASE! USE BALL POINT PEN ONLY PHYSICIAN'S ORDERS

DONALD MOSHIER
04/15/2005

Don this morning is still complaining of pain in his mid-chest area. It hurts to take a deep breath. It has been pretty much persistent all night. He has had no nausea or vomiting associated with it. He describes it mostly in the mid-epigastric area radiating into his back.

VITAL SIGNS: He is afebrile. P-64 BP-134/88, ranging 88 to 100 systolic.

On exam, his neck is supple, there is no jugular venous distention. His heart is regular, there is no S3 gallop or rub. Lungs are clear, no rales or rhonchi. He has some reproducible pain in his mid-epigastric and mid-chest area. Abdomen is soft, non-distended. Extremities show no edema.

LABORATORY DATA: His white count and hemoglobin from yesterday noted. His INR was 1.2, amylase 44, troponin 0.01.

DIAGNOSTIC IMPRESSION:
1. Mid-epigastric pain
2. Presumptive acute cholecystitis based on scans; no stones in the gallbladder however. Pain and symptoms mildly atypical but still possibly consistent with cholecystitis.

PLANS: The patient is scheduled for an upper endoscopy this morning to exclude any possibility of ulceration or peptic disease. Risks, benefits of endoscopic procedure discussed with the patient including the risk of puncturing his stomach, side effects from sedating medication or bleeding related to the procedure. He did agree today.

GARY ANDERSON, D.O.

D: 04/15/2005 0719
T: 04/15/2005 1052
GLA/kb

DONALD MOSHIER
04/16/2005

Don this morning continuing to complain of pleuritic type chest pain substernally. He states that when he takes a deep breath it hurts below his chest, in his mid-epigastric area. He has had no shortness of breath, productive coughing, indigestion, no further nausea. He has been able to tolerate his diet without difficulty. He has had no other changes in his bowel or bladder habits, no fevers or chills, or viral symptoms.

On physical examination, he generally is in no distress, appears relaxed. T-97 P-68 BP-150/78

On exam, his neck is supple, no JVD. His heart is regular, there is no S3 gallop or rub. His lungs are clear, there are no rales, rhonchi or wheezes. There is no pleuritic friction rub and no evidence of a rub over the chest. The abdomen is soft, tender in the mid-epigastric area, over the sternum and xiphoid. He has good bowel sounds. He has no right upper quadrant tenderness, no guarding or rebound.

LABORATORY DATA: CAT scan report is still pending. I did look at it myself. I don't see any obvious clot, no infiltrates in the lung, no evidence of pericardial effusion. An echocardiogram ordered yesterday was not done. The patient's SED rate is slightly elevated at 16. CPK 49, troponin 0.1 yesterday.

DIAGNOSTIC IMPRESSION: Chest pain which is reproducible, pleuritic in quality. Initial cardiac work-up is negative. His ultrasound of his gallbladder and CAT scan were suspicious regarding cholecystitis so those presentations somewhat atypical in my opinion, no stones, no fever. He is tolerating his diet without nausea. His pain location mid-epigastric. His CAT scan reviewed shows no evidence of an aneurysm. His risk factors for PE are generally low.

PLANS: Awaiting CAT scan report. In my opinion his symptoms are mostly musculoskeletal at this time but cannot exclude a pulmonary embolism definitively. D Dimers are sent out and not back. Will await CAT scan report but the situation described, the patient, my feeling is that it is musculoskeletal. Any changing symptoms, worsening symptoms, unresolving symptoms need further work-up. He should be adequate to treat him with antibiotics empirically for any possibility of cholecystitis. Ibuprofen or Tylenol as needed for pain. The patient is concerned because he is isolated over there and can't get the care that he may need. If the situation changes he may need to be observed an additional 24 hours pending the CAT scan report. His Ribavirin and Interferon to continue as an outpatient. His EGD reviewed with him again today.

GARY ANDERSON, D.O.

D: 04/16/2005 0928
T: 04/16/2005 1218
GLA/kb

DONALD MOSIER
04/16/2005
ADDENDUM

CAT scan reported negative. Verbal report from Radiology.

FINAL DIAGNOSIS: Musculoskeletal chest pain, rule out pleuritic chest pain

PLANS: The patient is stable for discharge.

GARY ANDERSON, D.O.

D: 04/1/6/2005 0940
T: 04/16/2005 1225
GLA/kb

Quest On Demand™

Associated Clinical Laboratories
CLIENT SERVICE 814.461.2400

PATIENT INFORMATION
MOSHIER,DONALD

DOB: 08/18/1961 Age: 43
GENDER: M

ID: 31916

REPORT STATUS **Final**

ORDERING PHYSICIAN
ANDERSON G

CLIENT INFORMATION
451187
KANE COMMUNITY HOSPITAL
NORTH FRALEY STREET
KANE, PA 16753

SPECIMEN INFORMATION
SPECIMEN: ET858566X
REQUISITION: 4511870006269
LAB REF NO: 4511870006269

COLLECTED: 04/14/2005 20:02
RECEIVED: 04/15/2005 19:26
REPORTED: 04/15/2005 21:07

COMMENTS: 124

Test Name	In Range	Out of Range	Reference Range	Lab
LIPASE, SERUM	261		114-286 U/L	A

Performing Laboratory Information:

A ASSOCIATED CLINICAL LABS 1526 PEACH STREET ERIE PA 16501

000327

Kane Community Hosp
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name **MOSHIER, DONALD**		Patient Phone (814) 362-8900	Room/Bed
Diagnosis **UNKNOWN**		Ordered **04/14/2005 1242 BAA**	Accession # **174468 STAT**
Admitting **Freeman, Richard** Ordering **Freeman, Richard** Attending **Freeman, Richard** Family		Scheduled **04/14/2005 1235 BAA**	Spec # **362143**
		Collected **04/14/2005 1254 MLW**	MR # **31916**
Patient Type **ER**	DOB / Sex **08/18/1961 M**	Admit/Discharge Date Admit **04/14/2005** Dischg **04/14/2005**	Received **04/14/2005 1255 PLH**
			Visit # **286109**

Test	Result	Flag	Range	Units	Date/Time/Tech
CHEMISTRY					
AMYLASE	44		29-103	U/L	4/14/2005 1350 MLW
LIVER PROFILE					
TP	7.1		5.4 - 8.1	g/dl	4/14/2005 1356 MLW
ALBUMIN	4.2		2.3 - 5.3	g/dl	4/14/2005 1358 MLW
GLOBULIN	2.9		2.6 - 3.1	g/dl	4/14/2005 1356 MLW
A/G RATIO	1.4		0.0 - 0.0		4/14/2005 1358 MLW
T BILI	* 1.4	H	0.1 - .9	mg/dl	4/14/2005 1358 MLW
D BILI	* 0.3	H	0.0 - .2	mg/dl	4/14/2005 1358 MLW
ALK PHOS	64		25 - 133	IU/L	4/14/2005 1356 MLW
ALT	* 89	H	3 - 35	iu/l	4/14/2005 1358 MLW
AST	* 65.0	H	16.0 - 38.0	iu/l	4/14/2005 1356 MLW
results repeated (04/14/2005 13:56 By MLW)					
CHEMSCREEN					
GLUCOSE	87		75.0 - 129.0	mg/dl	4/14/2005 1350 MLW
BUN	16		9.0 - 26.0	mg/dl	4/14/2005 1350 MLW
CREAT	0.9		0.4 - 1.6	mg/dl	4/14/2005 1350 MLW
Na	137		134.0 - 144.0	mmol/L	4/14/2005 1350 MLW
K	3.9		3.3 - 5.3	mmol/L	4/14/2005 1350 MLW
Cl	103		98.0 - 114.0	mmol/L	4/14/2005 1350 MLW
TCO2	26		20.0 - 34.0	mmol/L	4/14/2005 1350 MLW
ANION GAP	12				4/14/2005 1350 MLW
Ca	8.6		8.6 - 11.2	mg/dl	4/14/2005 1350 MLW

Order Comments:

fmd dr anderson

Name: MOSHIER, DONALD
MR #: 31916
Test: LIVER PROFILE, CHEMSCREEN, AMYLASE

Final Report
Page 1 of 1

Print: 4/14/2005 1:55:24PM

000328

Kane Community Hospi
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name				Patient Phone	Room/Bed
MOSHIER, DONALD				(814) 362-8900	
Diagnosis				Ordered	Accession #
UNKNOWN				**04/14/2005 1243 BAA**	**174470 STAT**
Admitting **Freeman, Richard**				Scheduled	Spec #
Ordering **Freeman, Richard**				**04/14/2005 1235 BAA**	**362146**
Attending **Freeman, Richard**				Collected	MR #
Family				**04/14/2005 1254 MLW**	**31916**
Patient Type	DOB	Sex	Admit/Discharge Date	Received	Visit #
ER	**08/18/1961**	**M**	Admit **04/14/2005** Dischg **04/14/2005**	**04/14/2005 1255 PLH**	**286109**

Test	Result	Flag	Range	Units	Date/Time/Tech
CHEMISTRY					
TROPONIN I	0.01		<.40	ng/ml	4/14/2005 1357 MLW

Order Comments:

Kane Community Hospi
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name **MOSHIER, DONALD**		Patient Phone (814) 362-8900	Room/Bed
Diagnosis **UNKNOWN**		Ordered **04/14/2005 1243 BAA**	Accession # **174470 STAT**
Admitting **Freeman, Richard** Ordering **Freeman, Richard** Attending **Freeman, Richard** Family		Scheduled **04/14/2005 1235 BAA**	Spec # **362145**
		Collected **04/14/2005 1254 MLW**	MR # **31916**
Patient Type **ER**	DOB / Sex **08/18/1961 M**	Admit/Discharge Date Admit **04/14/2005** Dischg **04/14/2005**	Received **04/14/2005 1255 PLH**	Visit # **286109**

Test	Result	Flag	Range	Units	Date/Time/Tech
CHEMISTRY					
CPK	37.0		4.0 - 230.0	iu/l	4/14/2005 1348 MLW

Order Comments:

Kane Community Hospi
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name				Patient Phone	Room/Bed
MOSHIER, DONALD				(814) 362-8900	
Diagnosis			Ordered		Accession #
UNKNOWN			**04/14/2005 1307 BAA**		**174480 STAT**
Admitting **Freeman, Richard**			Scheduled		Spec #
Ordering **Freeman, Richard**			**04/14/2005 1305 BAA**		**362158**
Attending **Freeman, Richard**			Collected		MR #
Family			**04/14/2005 1308 amb**		**31916**
Patient Type	DOB	Sex	Admit/Discharge Date	Received	Visit #
ER	**08/18/1961**	**M**	Admit **04/14/2005** Dischg **04/14/2005**	**04/14/2005 1308 AMB**	**286109**

Test	Result		Flag	Range	Units	Date/Time/Tech
UA		O				
URINE WITH MICROSCOPIC						
COLOR	Yellow					4/14/2005 1426 MLW
APPEARANCE	Clear					4/14/2005 1426 MLW
LEUKOCYTE	Negative			NEGATIVE		4/14/2005 1426 MLW
NITRITE	Positive			NEGATIVE		4/14/2005 1426 MLW
UROBILINOGEN	1.0 EU/dL				EU/dl	4/14/2005 1426 MLW
PROTEIN(UA)	negative			0 - 0		4/14/2005 1426 MLW
confirmed (04/14/2005 14:26 By MLW)						
pH	6.0					4/14/2005 1426 MLW
BLOOD	Trace			NEGATIVE		4/14/2005 1426 MLW
SP GRAVITY	1.025					4/14/2005 1426 MLW
KETONES	Negative			NEGATIVE		4/14/2005 1426 MLW
BILIRUBIN,(UA)	Negative			NEGATIVE		4/14/2005 1426 MLW
GLUCOSE UA	Negative			NEGATIVE		4/14/2005 1426 MLW
MICRO-WBC	0-5 /hpf			NEGATIVE		4/14/2005 1426 MLW
MICRO-BACTERIA	4+			NEGATIVE		4/14/2005 1426 MLW
C&S IF INDICATE	1					4/14/2005 1426 MLW

Order Comments:

DO YOU WANT A C&S IF UA IS POSITIVE?: yes, clean catch
URINE WITH MICROSCOPIC: Ordered as laboratory reflex order

Kane Community Hospi
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name				Patient Phone	Room/Bed
MOSHIER, DONALD				(814) 362-8900	M/S 124 2
Diagnosis			Ordered		Accession #
UNKNOWN, ESI-3			04/14/2005 1242 BAA		174468 STAT
Admitting	Anderson, Gary		Scheduled		Spec #
Ordering	Freeman, Richard		04/14/2005 1235 BAA		362142
Attending	Anderson, Gary		Collected		MR #
Family			04/14/2005 1254 MLW		31916
Patient Type	DOB	Sex	Admit/Discharge Date	Received	Visit #
INPATIENT	08/18/1961	M	Admit 04/14/2005 Dischg	04/14/2005 1254 PLH	286109

Test	Result	Flag	Range	Units	Date/Time/Tech
COAG					
PTT	28.0		0.0 - 45.0	sec	4/14/2005 2039 JLZ
PROTHROMBIN TIME PT					
PT	13.3		9.6 - 13.6	sec	4/14/2005 2039 JLZ
INR	* 1.2	L	2.0 - 3.0	INR	4/14/2005 2039 JLZ

EXCEPT FOR MECHANICAL PROSTHETIC VALVES AND
T -MYOCAR[illegible] INFARCTION INR = 2.5-3.5

Order Comments:

fwd dr anderson
Added Draw Charge

Kane Community Hospi
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name				Patient Phone	Room/Bed
MOSHIER, DONALD				(814) 362-8900	**M/S 124 2**
Diagnosis			Ordered		Accession #
UNKNOWN, ESI-3			**04/14/2005 1426 BAA**		**174480 STAT**
Admitting	**Anderson, Gary**		Scheduled		Spec #
Ordering	**Freeman, Richard**		**04/14/2005 1305 BAA**		**362177**
Attending	**Anderson, Gary**		Collected		MR #
Family			**04/14/2005 1308 amb**		**31916**
Patient Type	DOB	Sex	Admit/Discharge Date	Received	Visit #
INPATIENT	**08/18/1961**	**M**	Admit **04/14/2005** Dischg	**04/14/2005 1427 MLW**	**286109**

Test	Result	Flag	Range	Units	Date/Time/Tech
MICRO					
URINE C & S					
SOURCE	CLEAN CATCH				4/15/2005 1445 JLZ
COLONY COUNT	NO GROWTH				4/15/2005 1445 JLZ
PRELIMINARY	See Comment				4/15/2005 1445 JLZ
FINAL	NO GROWTH				4/15/2005 1445 JLZ

NO FURTHER TESTING PERFORMED.
(04/15/2005 14:45 By JLZ)

Order Comments:

DO YOU WANT A C&S IF UA IS POSITIVE?: yes, clean catch
URINE WITH MICROSCOPIC: Ordered as laboratory reflex order
URINE C & SOrder Added As Laboratory Reflex Order

Kane Community Hospi
North Fraley Street
Kane, PA 16735
814.837-8585

Laboratory Report

Final Report

Location:

Patient Name **MOSHIER, DONALD**		Patient Phone (814) 362-8900	Room/Bed
Diagnosis **UNKNOWN**		Ordered **04/14/2005 1242 BAA**	Accession # **174468 STAT**
Admitting **Freeman, Richard** Ordering **Freeman, Richard** Attending **Freeman, Richard** Family		Scheduled **04/14/2005 1235 BAA**	Spec # **362141**
		Collected **04/14/2005 1254 MLW**	MR # **31916**
Patient Type **ER**	DOB / Sex **08/18/1961 M**	Admit/Discharge Date Admit **04/14/2005** Dischg **04/14/2005**	Received **04/14/2005 1254 PLH**	Visit # **286109**

Test	Result	Flag	Range	Units	Date/Time/Tech
HEMATOLOGY					
CBC W/ MANUAL DIFF					
WBC	* 2.4	L	4.80 - 10.80	x 10 `3	4/14/2005 1346 MLW
RBC	* 4.04	L	4.70 - 6.10	x 10 `6	4/14/2005 1346 MLW
HGB	* 12.9	L	14.0 - 18.0	g/dl	4/14/2005 1346 MLW
HCT	* 37.4	L	42.0 - 52.0	%	4/14/2005 1346 MLW
MCV	93		80 - 99	fl	4/14/2005 1346 MLW
MCH	* 31.9	H	27.0 - 31.0	pg	4/14/2005 1346 MLW
MCHC	34.5		33.0 - 37.0	g/dl	4/14/2005 1346 MLW
PLT	* 94	L	130 - 400	x 10 `3	4/14/2005 1346 MLW
RDW	16.4		11.6 - 16.5	%	4/14/2005 1346 MLW
MPV	10.7		7.4 - 11.0	fl	4/14/2005 1346 MLW
LYMPH	24.3		15.0 - 41.0	%	4/14/2005 1346 MLW
MIXED	* 12.8	H	1.7 - 9.3	%	4/14/2005 1346 MLW
GRAN	62.9		42.2 - 75.2	%	4/14/2005 1347 MLW
MDIFF SEGS	* 67	H	35 - 65	%	4/14/2005 1347 MLW
MDIFF LYMPH	* 24	L	25 - 45	%	4/14/2005 1347 MLW
MDIFF MONO	8		1 - 8	%	4/14/2005 1347 MLW
MDIFF EOSO	1		0 - 4	%	4/14/2005 1347 MLW
RBC MORPH	See Comments				4/14/2005 1347 MLW
2+ ANISOCYTOSIS					
2+ MACROCYTOSIS					

Order Comments:

fmd dr anderson
CBC WITH MANUAL DIFF: Ordered as laboratory reflex order
CBC W/ MANUAL DIFF: Ordered as laboratory reflex order

Associated Clinical Laboratories
CLIENT SERVICE 814.461.2400

SPECIMEN INFORMATION
SPECIMEN: ET859284I
REQUISITION: 4511870006289
LAB REF NO: 4511870006289

COLLECTED: 04/15/2005 08:35
RECEIVED: 04/15/2005 19:01
REPORTED: 04/15/2005 20:46

PATIENT INFORMATION
MOSHIER,DONALD

DOB: 08/18/1961 Age: 43
GENDER: M

ID: 31916

REPORT STATUS **Final**

ORDERING PHYSICIAN
ANDERSON,GARY

CLIENT INFORMATION
451187
KANE COMMUNITY HOSPITAL
NORTH FRALEY STREET
KANE, PA 16753

COMMENTS: 124-2

Test Name	In Range	Out of Range	Reference Range	Lab
D-DIMER				
D-DIMER (EIA)	338		< 500 ng/mL	A
	THIS ASSAY IS A QUANTITATIVE ELISA INTENDED FOR USE AS AN AID IN THE DIAGNOSIS OF PE AND DVT WITH A HIGH NEGATIVE PREDICTIVE VALUE.			

Performing Laboratory Information:

A ASSOCIATED CLINICAL LABS 1526 PEACH STREET ERIE PA 16501

000335

Preliminary Radiology Report

Patient Name [illegible]

Physician Name [illegible] Date 11-15-05

ER ___ ICU ___ INPT [illegible] OP ___

Exam(s) CT Chest

Report without & with contrast

Normal

Radiologist Signature ___

Verbal report date and time ___

Radiologist giving verbal ___

Technologist taking verbal report ___

Preliminary Radiology Report

Patient Name Donald Mosher

Physician Name _____ Date _____

ER ✓ ICU ___ INPT___ OP ___

Exam(s) _____

Report U.S. of Upper abd

Distended gall-bladder, filled with sludge and very thick edematous wall. Consistent with acute cholecystitis.

Radiologist Signature _____

Verbal report date and time _____

Radiologist giving verbal _____

Technologist taking verbal report _____

KANE COMMUNITY HOSPITAL
KANE, PA

RADIOLOGY REPORT

NAME: DONALD MOSHIER
PO BOX 5000
BRADFORD , PA 16701
814-3628900

MED REC #: 31916 ADM #: 286109
DATE OF BIRTH: 08/18/1961 AGE: 43Y

PHYSICIAN: RICHARD E FREEMAN, M.D. ROOM: INPATIENT
DATE OF EXAM: 04/14/2005 X-RAY #: 36625

Clinical information: Chest pain, right upper abdominal pain, history of cirrhosis and hepatitis. Gallbladder disease.

ULTRASOUND OF THE UPPER ABDOMEN:

The liver is ultrasonographically normal. However, predominantly functional hepatocellular disease may not be demonstrable ultrasonographically and further clinical correlation is requested. There are no space occupying lesions within the liver.

There is no dilatation of the biliary duct system and the common bile duct measures 4.0 mm.

The gallbladder is moderately distended. It is filled with sludge. The gallbladder wall is significantly thickened, measuring up to 10.0 mm. There is no pericholecystic fluid collection. However, from the overall appearance, the findings would be consistent with acute cholecystitis.

There are no other significant findings.

IMPRESSION: Changes in the gallbladder which are consistent with acute cholecystitis as discussed above. Clinical correlation is also requested. If there is any question clinically, then further evaluation with HIDA scan may also be judicious.

JAMIL SARFRAZ, M.D.
RADIOLOGIST

D: 04/14/2005 1628
T: 04/15/2005 1435
JS:sln

000338

KANE COMMUNITY HOSPITAL
KANE, PA

RADIOLOGY REPORT

NAME: DONALD MOSHIER
PO BOX 5000
BRADFORD , PA 16701
814-3628900

MED REC #: 31916 ADM #: 286109
DATE OF BIRTH: 08/18/1961 AGE: 43Y

PHYSICIAN: RICHARD E FREEMAN, M.D. ROOM: INPATIENT
DATE OF EXAM: 04/14/2005 X-RAY #: 36625

Clinical information: Substernal chest pain radiating to the back; back pain; gallstones; status post appendectomy.

CHEST - PA AND LATERAL VIEWS:

The study is normal.

CT SCAN OF THE ABDOMEN AND CT SCAN OF THE PELVIS:

The study was performed without and then with intravenous contrast administration. Oral contrast medium was also administered.

The following observations are made:

1. The liver, spleen, pancreas, adrenal glands, and the kidneys are normal.

2. The gallbladder wall is thickened and edematous. The appearance is consistent with acute cholecystitis. Within the gallbladder, there is rim-like density which either is part of thickened inflamed wall, or may represent partially calcified calculus. Further correlation with ultrasound examination may also be helpful.

3. There is no dilatation of the biliary duct system.

4. The remainder of the CT scan of the abdomen and CT scan of the pelvis are unremarkable.

IMPRESSION: Evidence of acute cholecystitis. Further correlation with ultrasound examination is also requested.
The remainder of the examination is unremarkable.

JAMIL SARFRAZ, M.D.
RADIOLOGIST

D: 04/14/2005 1535
T: 04/15/2005 1421
JS:sln

000339

KANE COMMUNITY HOSPITAL
KANE, PA

RADIOLOGY REPORT

NAME: DONALD MOSHIER
PO BOX 5000
BRADFORD , PA 16701
814-3628900

MED REC #: 31916 ADM #: 286109
DATE OF BIRTH: 08/18/1961 AGE: 43Y

PHYSICIAN: GARY ANDERSON, D.O. ROOM: INPATIENT
DATE OF EXAM: 04/15/2005 X-RAY #: 36625

Clinical information: Mid epigastric and lower chest pain. Acute cholecystitis.

CT SCAN OF THE CHEST:

The study was performed without and then with intravenous contrast administration.

The examination is normal, specifically, there is no evidence of pulmonary embolism. There is no acute pneumonic infiltrate.

JAMIL SARFRAZ, M.D.
RADIOLOGIST

D: 04/15/2005 1822
T: 04/16/2005 0935
JS:sln

000340

FMD: ANDERSON

31916/286109 04/14/2005 11:27:04 Moshier, Donald L Kane Community Hospital
43 years Male White 280 lbs 73 ins BP:170/100 Dept: er
Room: cardiac
Rx:
Dx: Chest Pain Oper: lmg

. NORMAL SINUS RHYTHM, RATE 82.....normal P axis, PR, rate & rhythm

Rate	82
PR	191
QRSD	104
QT	354
QTc	413

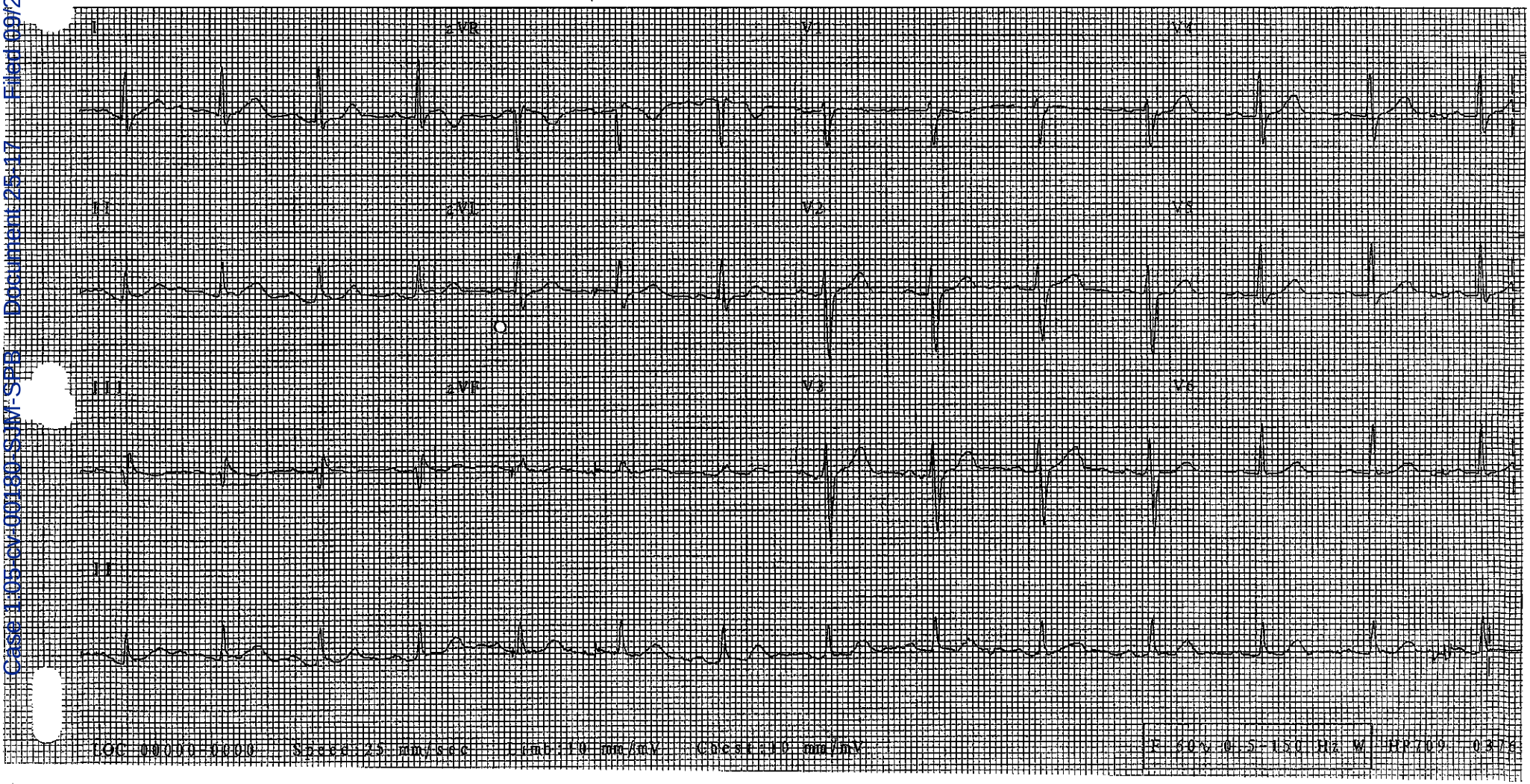
--AXIS--

P	60
QRS	33
T	17

Requested by:
Dr Freeman

000341

- NORMAL ECG - RE[illegible]RY MD MUST REVIEW



31916 / 286109 04/15/2005 09:33:00 AM MOSHIER, Donald
43 years Male White 280 lbs 73 ins BP:

The Kane Community hospital
Dept: MS1
Room: 124-2
Oper: sb

Rx:
Dx:

Rate 67
PR 199
QRSD 99
QT 387
QTc 408

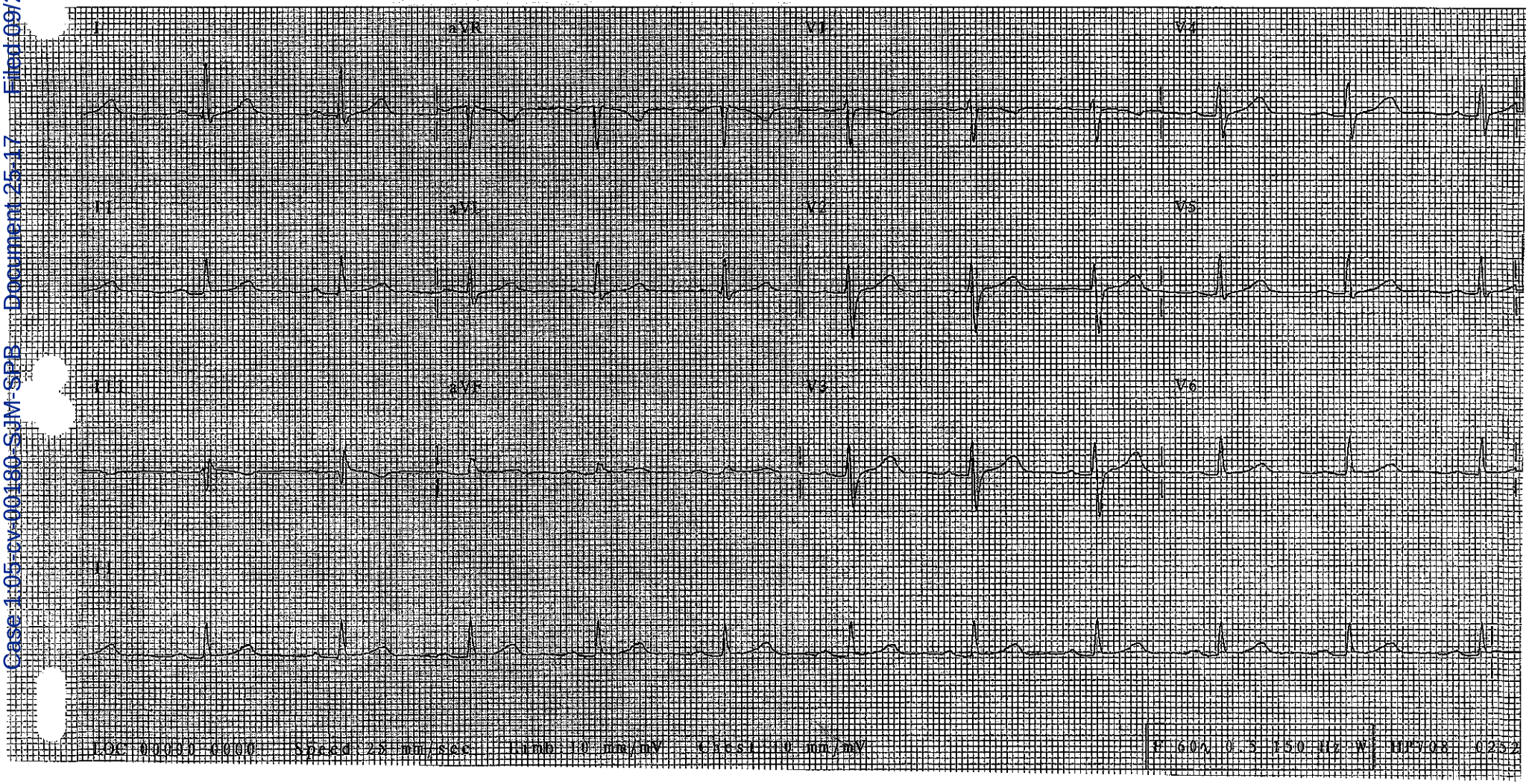
--AXIS--
P 35
QRS 24
T 15

. Normal sinus rhythm, rate 67.....Normal P axis, PR, rate & rhythm

NO PREVIOUS EKG AVAILABLE - NORMAL ECG -

Requested by:
Dr Anderson

0000342



KANE COMMUNITY HOSPITAL
KANE, PA

OPERATIVE REPORT

NAME: DONALD MOSHIER
MEDICAL RECORD #: 31916 ADM #: 286109
DATE: 04/15/2005

PREOPERATIVE DIAGNOSIS: Mid epigastric pain. Dyspepsia. Rule out peptic disease.

POSTOPERATIVE DIAGNOSIS: Mild gastritis. No esophageal varices, gastric or duodenal ulcers. Biopsies of the antrum to rule out Helicobacter.

OPERATION: Esophagogastroduodenoscopy

SURGEON: Gary Anderson, D.O.

ANESTHESIA: Intravenous sedation

PROCEDURE: The patient was admitted to the OR and identified, placed in the left lateral recumbent position. After appropriate intravenous sedation, after Cetacaine spray for local anesthesia a well lubricated endoscope was inserted into the first part of the esophagus and advanced by direct vision to the distal esophagus to the gastroesophageal junction, into the stomach, to the pylorus, into the duodenum. The first three parts of the duodenum were examined and were normal in appearance. The instrument was pulled back into the stomach. The entire mucosa of the stomach was examined and was normal in appearance with the exception of some mild antral gastritis. Biopsies were done to exclude Helicobacter. The instrument was then pulled back into the esophagus. Again the distal esophagus appeared normal. The ora serrata was well formed. There was no hiatal hernia. There was no evidence of any varices. The patient has a notable history of cirrhosis. The instrument was then gradually removed, decompressing the stomach and the esophagus as it was removed. The patient tolerated the procedure well.

GARY ANDERSON, D.O.

D: 04/15/2005 0757
T: 04/19/2005 1013
GLA:sln

000343

SURGICAL PATHOLOGY CONSULTATION

HAMOT MEDICAL CENTER LABORATORY
Pathology Associates of Erie, Inc.
201 State Street
Erie, PA 16550
(814) 877-2241

ume: **MOSHIER, DONALD**
rgical#: **02-SP-05-05760**
dering Physician: ANDERSON, GARY L., DO
ocation: KANE

Med Rec #: (00002)528781
Hospital#: 0000002504307 66
SS#: - -
DOB: 08/18/61
Age/Sex: 43 YRS M

Procedure Date: 04/15/05
Date Received: 04/18/05
Date Printed: 04/18/05

RE-OP DIAGNOSIS:
Mid-epigastric pain

ROCEDURE:
Biopsy

PECIMEN:
Antrum

iROSS DESCRIPTION:
Received in formalin, labeled with the patient's name and "antrum", are two fragments of soft light tan tissue measuring 0.4 x 0.2 x 0.2 cm. in aggregate. The specimen is entirely submitted in one cassette.

BAM/jet

IICROSCOPIC DESCRIPTION:
Performed and confirms final diagnosis.

)IAGNOSIS:
Gastric antrum, mucosal biopsies:
Gastric mucosa, no active gastritis, intestinal metaplasia or malignancy identified.

No H. pylori micro-organisms identified by special stain.
P1

DLK/jet
Report Diagnosed By: DAVID L. KLAWON, MD
Report Verified By: DAVID L. KLAWON, MD
(Electronic Signature)
Verified Date: 04/18/05

PHYSICIAN:
KANE COMMUNITY HOSPITAL LAB
N. FRALEY ST. PO BOX 778
KANE
PA 16735-

Copies to: GARY L. ANDERSON, DO

000344

** End of Report **

10929-052

Patient: **MOSHIER,DONALD**
Acct#: **V04546554**
Unit#: **M000226525**

Age/Sex: **43/M**
DOB: **08/18/1961**
Physician: **Graham,Nathaniel MD**

Location: **4EAST**
Rm/Bed: **446A-1**

Specimen # **S05-1355** Received: **04/20/05 - 1237** Specimen Type: **SURGICAL**

MEDICAL CODES

CODES: T-63000 - Gallbladder

COPIES TO

Graham,Nathaniel MD
300 Hooker Fulton Bldg
Bradford, PA 16701
(814)368-7125

Miskiel,Edward J MD
116 Interstate Parkway
Bradford, PA 16701
(814)362-8425

PTH PROCEDURES COMPLETE

PROCEDURES: HE STAIN (04/20/05-1238)

SPECIMEN/LOCATION

TISSUES:
Gallbladder - Gallbladder

Packet reviewed
11.08.05
HCV
11.08.05

GROSS DESCRIPTION

The specimen received in formalin consists of previously opened gallbladder, measuring 10 x 4 x 3.5 cm with an oval, transmural defect; measuring 1.7 x 1.5 cm in the fundus. The lumen contains small amount of reddish-brown bile and blood clots. No stones are identifiable. The wall is rubbery, edematous, thickened, varying from 0.3 to 0.8 cm in maximum thickness with focal hemorrhage, edema and congestion. Representative sections are submitted.

MICROSTUDY DIAGNOSIS

Gallbladder:
Acute cholecystitis.

DATE OF OPERATION

04-19-05

PROCEDURE

Open Cholecystectomy

PRE-OPERATIVE DIAGNOSIS

Severe Cholecystitis

Signed _____ SYED ALLY, MD 04/22/05
<signature on file>

MOSHIER,DONALD A#V04546554 DOB: 08/18/1961

Bradford Regional Medical Center

116 Interstate Parkway
Bradford, Pa 16701

Department of Medical Records

Patient: MOSHIER,DONALD **Medical Record #:** M000226525 **Acct #:** V04546554

DOB: 08/18/1961 **Age:** 43 **Sex:** M

Admitting MD: Graham, Nathaniel MD **Room/Bed:** 446A-1 **Location:** 4EAST

Admit Date: 04/18/05 **Discharge Date:** 04/27/05 / 1347

DISCHARGE SUMMARY

DISCHARGE DIAGNOSIS: Severe acute cholecystitis with signs of gangrene at the gallbladder clinically.

PROCEDURE: Open cholecystectomy.

HISTORY: See HP.

HOSPITAL COURSE: The patient was brought to the hospital and given intravenous fluids and antibiotics in an attempt to cool down his cholecystitis. This was unsuccessful, and he required emergent operation. Because of the amount of guarding and expected amount of inflammation, it was planned as an open procedure which was carried out without complications. He recovered very well, particularly considering his comorbidities including hepatitis C with cirrhosis. He improved gradually. JP drain was left in for 5 days. Kept on Zosyn as an antibiotic. He is now eating regular food. The incision is healing well. He has been having some diarrhea in the last 24 to 48 hours. It appears to be related to his antibiotics. We will get a stool titer for C. difficile. Started him on acidophilus, and I have discussed with Dr._____at FCI McKean. He has now been in the hospital for 8 postop days and is ready to be discharged, and he will be followed by the physicians at FCI McKean.

PROGNOSIS: Good in the short term for his cholecystitis. Guarded for his hepatitis.

Job#: 4560034 / 891280

Signed By: _____
Graham, Nathaniel MD

GRAHNA/PRECYSE
DDT: 04/27/05 0911
TDT: 04/27/05 2159
Report Number: 0427-0062
cc:
FCI MCKEAN
Graham, Nathaniel MD

Bradford Regional Medical Center

116 Interstate Parkway
Bradford, Pa 16701

Department of Medical Records

Patient: MOSHIER,DONALD **Medical Record #:** M000226525 **Acct #:** V04546554

DOB: 08/18/1961 **Age:** 43 **Sex:** M

Attending MD: Graham,Nathaniel MD **Location:**
4EAST

Date of Service: 04/18/05

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Acute surgical abdomen with acute cholecystitis, possible gangrenous cholecystitis.

POSTOPERATIVE DIAGNOSES:
1. Gangrenous cholecystitis with intrahepatic gallbladder.
2. Cirrhosis from hepatitis C.

PROCEDURE: Open cholecystectomy.

SURGEON: Nathaniel L. Graham, MD

ANESTHESIA: General.

FINDINGS: The gallbladder was densely edematous, thickened, and obviously inflamed. It could not be grasped because of the tension. Therefore, trocar was used to aspirate the gallbladder. Cultures of the gallbladder were taken. Inside of the gallbladder was necrotic, and this necrosis extended down to the biliary duct system. The gallbladder was 50% intrahepatic in a hard macronodular cirrhotic liver. The liver could not be moved to manipulate easily, and the base of the gallbladder and the intrahepatic portion was difficult to access and carve out. Therefore, the gallbladder was removed as much as possible, and a small portion of the base left intrahepatically and the Bovie at 80 W used to destroy the gangrenous tissue. At the end of the procedure, Surgicel was placed over this for completion of hemostasis and_____drain placed along this area to suction the debris. The triangle of Calot was edematous from chronic and acute inflammation. With disruption of all tissue planes, careful dissection was made from the top down along the gallbladder to the base of the gallbladder, and 2 branched arteries impinging on the gallbladder divided with Hemoclips and a single very thickened cystic duct identified, divided off the gallbladder over a clamp, and then opened in the inside and examined, while the outer portion of the cystic duct was pink, inflamed, but not gangrenous. The inner mucosa was black with the appearance of gangrene. This was ligated carefully with a 0 silk tie and then 3 Hemoclips placed distal to the tie for markings should future exploration be required in this very difficult case.

DETAILS OF PROCEDURE: The patient was brought to the operating room and identified by myself as Donald Moshier. He was placed on the operating table in supine position. After induction of anesthesia and endotracheal intubation, the nasogastric tube and Foley catheter were placed and the abdomen prepped with Betadine and draped with sterile linen. Right subcostal incision was performed 2 fingerbreadths below the costal margin, carried through the skin with a knife and deep tissues with electrocautery. The anterior fascial sheath was incised and then a muscle-sparing incision performed dissecting the fascia from the muscles superiorly and inferiorly, retracting the muscle medially and laterally with Bookwalter retractor system exposing the deep muscular fascial layers. These were divided underneath the rectus muscle with electrocautery and the abdomen entered without injuring intra-abdominal contents. The bowel was packed inferiorly over rolled moistened gauze packs using the Bookwalter system exposing the edematous gallbladder. Trocar was

used to aspirate the gallbladder and then the opening was grasped with a Kocher clamp and the electrocautery used to dissect the plane between the liver and the gallbladder. This was quite difficult because of the firm edema and gangrenous nature of the tissues. The gallbladder was dissected as much as possible. Small portions of the posterior bed could not be even removed from the gallbladder angles such that visualization was difficult. The liver on palpation was firm and not easily mobile, and several attempts to angulate this for deeper exposure would result in cracking this macronodular cirrhotic liver. Therefore, the gallbladder was removed where it could be placed on appropriate tension and the remainder of the base per liver bed destroyed with electrocautery. A pack was placed in the liver bed, and sweetheart retractor used to elevate this gently, and the rest of the gallbladder dissected down to the infundibulum. At this point, several branches of the hepatic artery were identified impinging into the gallbladder. These were 1.5- to 2-mm size and were divided over Hemoclips. Gallbladder was carefully skeletonized using right-angle clamps and Kitner dissector down to a single thickened widened cystic duct. External edematous diameter was approximately 5 mm. This was divided over clamps and ligated. Internal diameter was approximately 2.5 mm to 3 mm. The inner wall was black. The gallbladder was removed to specimen. Packs were placed and then removed after 5 minutes and the gallbladder bed reinspected. Cautery was used to obtain hemostasis and then a Surgicel over sponge placed with pressure on the liver bed for 5 minutes and then sponge removed and hemostasis was complete. Surgicel was then placed over the cystic duct and vascular stumps. The common duct itself appeared to be very deep within more edematous friable infected tissue just below the 7 to 8 mm cystic duct stump. After ligating the cystic duct with 0 silk tie, 3 distal Hemoclips were placed and retractors removed. The gallbladder bed was irrigated with saline and dried. A #10 Jackson-Pratt drain was placed along the gallbladder bed in the liver and into the Morrison pouch brought through a lateral incision. The abdomen was closed in layers using #1 PDS. The skin was closed with staples. Drain was sutured to the skin with 3-0 nylon. Sterile dressings were placed to the wound. The patient tolerated the procedure well.

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Signed By: _____

Graham, Nathaniel MD

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cc:
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